STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155377	A. BUILDING 00 B. WING	08/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEYMOUR CROSSING	707 S JACKSON PARK DR SEYMOUR, IN 47274

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the Investigation of Complaints IN00114311 and IN00114658. This visit resulted in a partially extended survey-immediate jeopardy. Complaint IN00114311, Substantiated, Federal/State deficiencies related to the allegations are cited at F-248, F-314, F-315 and F-329. Complaint IN00114658, Substantiated, Federal/State deficiencies related to the allegation are cited at F-323. Unrelated deficiency cited. Survey dates: August 22, 23 and 24, 2012. Facility number: 000272 Provider number: 155377 AIM number: 100274710 Survey team: Sharon Lasher, RN/TC Angel Tomlinson, RN Census bed type: SNF/NF: 79 Total: 79	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Census payor type: Medicare: 13 Medicaid: 61 Other: 5 Total: 79 Sample: 9 These deficiencies reflects state findings cited in accordance with 410 IAC 16.2. Quality review completed on August 30, 2012 by Bev Faulkner, RN			

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F0248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. Based on observation, interview and record review, the facility failed to provide activities for a resident to assist with the resident's well being for 1 of 3 residents reviewed for activities in a total sample of 9. (Resident #A) Findings include: Resident #A's record was reviewed on 8/22/12 at 1:10 p.m. Resident #A's diagnoses included, but were not limited to, depression, anemia, atrial fibrillation, heart failure, urinary tract infection, diabetes mellitus and osteoporosis. Resident #A's MDS (Minimum Data Set), assessment, dated 8/3/12, indicated Resident #A's BIMS (Brief Interview for Mental Status) was 10, with a range of 8-15, indicating moderately impaired cognition and activities, it was somewhat important for her to be around pets, do her favorite activities and go outside and get fresh air when the weather was good. It was very important to the resident to participate in religious services or	F0248	It is the practice of this provider facility to provide an ongoing program of activities designed to meet, in accordance with comprehensive assessment of interests and physical, mental, and psychosocial well-being of each resident. 1. A. Resident A will receive appropriate ongoing activity program designed to meet her needs including an updated activities assessment and was placed on 1:1's 2X weekly through next assessment. B. Resident A will be encouraged to be involved in group activities of interest and encouraged to participate in her 1:1 programming. 2. A. Current residents to have new assessment to obtain/update all current activities interests and needs. B.On-going residents will be review quarterly, annually, and upon any change of conditions for their activity needs. C.Activities will maintain participation logs to assess each resident's participation. D.Residents who choose to decline to be involved in group activities will be offered 1:1 visitation from staff to achieve activity needs. Activity staff will be	09/23/2012

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	practices. The activity assessment for Resident #A, dated 8/20/11, indicated the resident was protestant and enjoyed country music. The resident's interest were bingo, sewing/quilting/knitting, woodworking, restaurants, museums, theater, the zoo and playing cards. The resident's favorite activities that were very important to her were religious services, bingo, crafts, fishing, shopping, dining, TV and music. During an interview with Resident #A's family member on 8/22/12 at 9:00 a.m., the family member indicated the facility did not encourage or offer the resident to become involved in activities. The family member indicated prior to being admitted to the facility the resident was very active in an activity program. The family member indicated the resident loved to play bingo, a variety of card games and made a lot of arts and crafts. During an interview with the Activity Director on 8/22/12 at 5:30 p.m., she indicated Resident #A had never attended group activities. She also indicated she felt Resident #A would not want 1:1 activities because "she just does her own thing" so Resident #A had not received any 1:1 activities.		in serviced on the provision of one on one activities by the social service consultant by 9/23/12 3. A. Residents will be provided with an ongoing activity program by the activity director that will be reviewed upon admission, quarterly, annually, and upon a significant change. B. If the resident does not choose to be involved in group activities the resident will be provided with a program in accordance with the comprehensive assessments, the interests, and physical, mental, and psychosocial well being. C.Resident Council Meeting will be offered to evaluate the current activity choices offered and obtain resident feedback, making changes appropriately. D. Activity staff will be in serviced on the provision of one on one activities by the social service consultant by 9/23/12 4. A. Activity Director /designee will conduct an audit of activities using the quality indicator, 5 times/week x 4 weeks then weekly x 12 weeks, then quarterly thereafter. Results of audits will be presented to the CQI Committee for review and follow up. An action plan will be developed for identified issues. B. Resident council will be asked to evaluate the activity offerings/programs in future resident council meetings.5. Compliance Date 9/23/2012	

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	During an observation on 8./23/12 at 12:00 p.m., Resident #A was in her room, up in a chair with the light in her room off. She was awake and looking around but there was not a TV on or a radio playing. During an interview with Resident #A on 8/23/12 at 12:05 p.m., she indicated she did not want to go to group activities but she would like for someone to visit with her and do activities like play cards with her in her room. She indicated she liked to play euchre and that takes four players, but she would like to play Skip-bo or Uno. A document titled "Activities" provided by the Administrator on 8/23/12 at 9:00 a.m., dated 1/06, and indicated by the Administrator to be the most current policy, indicated "Policy, It is the policy of this facility to provide for an ongoing program of activities designed to meet the interests and the physical, mental, and psychosocial well-being of each resident in accordance with the comprehensive assessment." This federal tag relates to complaint IN00114311. 3.1-33)a) 3.1-33(b)(8)			

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F0309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on observation, interview and record review, the facility failed to educate and train CNA's how to assist a resident with a right femur fracture with safe bed mobility and transfers for 1 of 1 resident sampled for quality of care in a total sample of 9 (Resident #B). Findings include: Review of the record of Resident #B on 8-22-12 at 1:35 p.m., indicated the resident's diagnoses included, but were not limited to, closed displaced right femur fracture, sacral decubitus ulcer, anemia, diabetes, dementia, anxiety and depression. The Minimum Data Set (MDS) assessment for Resident #B, dated 8-8-12, indicated the following: bed mobility- extensive assistance of one person, walk in room- did not occur and toilet use- extensive assistance of two people.	F0309	It is the practice of this provider to ensure the resident's environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. 1. Resident B will be transferred per C.N.A assignment sheet instruction and direction 2. A. Residents requiring transfers have the potential to be affected B. Nursing staff have been in serviced on proper transfer techniques by licensed therapist/designee by 9/23/12.3. A. PT/Designee will conduct skills validation for C.N.A's staff for proper transfer techniques B. Charge nurse/designee will conduct rounds on all shifts to ensure residents are properly transferred according to the C.N.A assignment sheet. The C.N.A assignment sheet will be changed durning morning clinical meeting by DNS/ designee. The updated C.N.A assignment sheets will be provided to staff daily Monday-Friday by DNS/ designee. The charge nurse will	09/23/2012

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	The x-ray for Resident #B, dated 8-12-12, indicated the resident had a right femoral fracture. The Interdisciplinary progress note for Resident #B, dated 8-13-12 at 9:00 a.m., indicated on 8-10-12, the resident was being assisted to the restroom by one CNA and a gait belt to the toilet. The resident complained of pain and became weak and the CNA assisted the resident to the floor. The resident acquired a fracture and was sent to the hospital for treatment and evaluation. The discharge summary from the local hospital for Resident #B, dated 8-20-12, indicated the resident presented to the emergency room on 8-13-12 after having a fall at her nursing home 2-3 days previously. The initial x-ray report was negative, the resident had persistent pain and a repeat x-ray showed a comminuted oblique fracture through the lower diaphysis of the right femur. The resident had rod placement in the right femur on 8-16-12 "which was accomplished with significant complications." The discharge instructions included, but were not limited to, wear knee immobilize on her right knee when in bed and when up with physical therapy, weight bearing as tolerated to right lower extremity with walker and gentle range of motion with		review C.N.A assignment sheets with C.N.As at the start of each shift. 4. To ensure compliance, the DNS/Designee is responsible for the completion of the transfer technique skills validation form daily for 1 week, bi weekly for 1 week, bi-monthly times 2 months, and then quarterly until continued compliance is maintained for 2 consecutive quarters. One skills validation will be completed on each unit per shift. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. 5.Compliance Date 9/23/12	

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	right knee daily. The nurses notes for Resident #B, dated 8-20-12 at 3:00 p.m., indicated the resident was resting in bed with immobilizer on the right leg. The resident was reoriented to place and time. Review of the CNA assignment sheet provided by the Director Of Nursing (DON) on 8-22-12 at 1:35 p.m., indicated Resident #B required two people to assist with mobility and transfers. During observation on 8-22-12 at 1:45 p.m., CNA #6 and CNA #7 provided incontinence care for Resident #B. The resident had persistent loose stools during the care and had to be turned from side to side in her bed four times. The resident yelled in pain during the care. When queried about getting the resident up to the bathroom or using a bed pan, CNA #6 and CNA #7 indicated no one had told them how to care for Resident #B since the resident was admitted back to the facility on 8-20-12. CNA #6 and CNA #7 indicated they had not been educated or trained on how to turn the resident, transfer the resident or provide any of her care. CNA #7 indicated the resident usually would go the bathroom, but had not been gotten up out of bed since she had returned from the hospital. CNA #6			

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	and CNA #7 indicated they felt the facility did not communicate resident's care needs and felt there had to be an easier way to care for Resident #B that would be more comfortable for the resident. Interview with the Physical Therapist (P.T.) on 8-22-12 at 2:25 p.m., indicated Resident #B was moderate assist with transfers prior to the fall, P.T. indicated the resident was maximum assist for transfers at this time due to the resident had an immobilizer on her right leg. During observation on 8-22-12 at 4:10 p.m., CNA #8, CNA #9 and the P.T. transferred Resident #B from the bed to wheelchair with a gait belt. The resident yelled in pain during the transfer. The transfer required several attempts to get the resident from the bed to the wheelchair with the assistance of three staff. Interview with P.T. on 8-22-12 at 5:15 p.m., indicated Resident #B required three staff to transfer from one place to another because the right leg had to be kept straight by a third staff member during the transfer. When queried how the CNA's were made aware of how to care for Resident #B with transfer, bed mobility and basic care needs, the P.T. indicated			

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	the nurse could tell them or the CNA's could read the Physical Therapy notes. The P.T. also indicated the CNA's could tell each other how to care for Resident #B during shift report. Interview with CNA #7 on 8-24-12 at 12:55 p.m., indicated she was caring for Resident #B. CNA #7 indicated no one had trained or educated her yet on how to transfer the resident. CNA #7 indicated she had not transferred the resident yet. CNA #6 provided the CNA assignment sheet at this time and it indicated the resident was to be transferred and toileted by two staff. Interview with CNA #6 on 8-24-12 at 2:15 p.m., indicated she was caring for Resident #B. CNA #6 indicated she had not been trained or educated on how to transfer the resident. 3.1-37(a)			

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F0314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, interview and record review, the facility failed to have a Stage IV pressure ulcer covered with a dressing and treatment for 1 of 3 residents sampled for pressure ulcers in a total sample of 9 (Resident #B). Finding include: Review of the record of Resident #B on 8-22-12 at 1:35 p.m. indicated the resident's diagnoses included, but were not limited to, closed displaced right femur fracture, sacral decubitus ulcer, anemia, diabetes, dementia, chronic diarrhea, anxiety and depression. The discharge summary from the local hospital for Resident #B, dated 8-20-12, indicated the resident had a sacral decubitus ulcer. The resident had significant skin breakdown and	F0314	It is the practice of this facility to ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's conical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. 1. A. Resident B will have dressing changes and treatment per treatment administration record (TAR) and as needed. The nursing staff has been in serviced on pressure wound care procedures by the Director of Nursing Service/designee by 9/23/12. B. The C.N.As will be made aware of residents with pressure areas by their assignment sheet and be educated on reporting to their charge nurse if a residents dressing and treatment is no longer intact. 2. A. All residents with dressing treatments and	09/23/2012

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	excoriation in her genital area as well as a significant sacral decubitus ulcer. The resident presented to the emergency room on 8-13-12 after having a fall at her nursing home 2-3 days previously. The initial x-ray report was negative, the resident had persistent pain and a repeat x-ray showed a comminuted oblique fracture through the lower diaphysis of the right femur. The resident had rod placement in the right femur on 8-16-12 "which was accomplished with significant complications." The discharge instructions included, but were not limited to, wear knee immobilize on her right knee when in bed and when up with physical therapy, weight bearing as tolerated to right lower extremity with walker and gentle range of motion with right knee daily. The pressure wound skin evaluation report for Resident #B, dated 8-20-12, indicated the resident had a Stage IV pressure ulcer (full thickness tissue loss with exposed bone, tendon or muscle, slough or eschar may be present) on the coccyx measuring 5.2 centimeters (cm) by 3.0 cm by 0.3 cm depth. The tissue had slough and was necrotic/eschar. The "Nursing Admission Assessment" for Resident #B, dated 8-21-12 at 1:35 p.m., indicated no documentation of the		pressure ulcers have the potential to be affected B. Nursing staff will be in serviced on pressure wound care procedures by Director of Nursing Services/ designee by 9/23/12. C. Residents with pressure ulcers were assessed by DNS/ designee to ensure pressure ulcer treatments and dressings were in place and follow physicians orders 3. A. Nursing staff will be in serviced on pressure wound care procedures by Director of Nursing Services/designee by 9/23/12 B. DNS/Designee will ensure treatment order will be obtained and followed as prescribed by the physician by auditing all MD orders during the clinical meeting. The Unit Manager/Designee will audit the TAR 3x weekly for compliance. The nurses will be held accountable for all treatments scheduled for their assignment, and disciplinary action will occur if not in compliance with the MD orders, up to and including termination. C. Charge nurse will check placement of the prescribed treatment for the pressure ulcer each shift and document on the TAR. D. Dressings/treatments will be monitored for placement each week during wound rounds by DNS/Designee. E. Care plan and C.N.A assignment sheet will be updated to include appropriate wound information by nurse management. 4. To ensure	

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	resident's Stage IV pressure ulcer. The nurses notes for Resident #B, dated 8-21-12 at 3:30 p.m., indicated it was a late entry for 8-20-12 at 7:30 p.m. The resident had a full head to toe skin assessment completed. The resident had open excoriation to the left groin folds. The resident had an open area on the coccyx with Mepilex covering the area. The physician was notified of the new areas. Waiting on a reply back from the physician. The physician telephone order for Resident #B, dated 8-22-12 (no time), indicated may use calcium alginate and cover with transparent dressing until santyl/polysporin 1:3 mixture arrives. The care plan update for Resident #B, dated 8-22-12, indicated the problem was a pressure area to the coccyx. The interventions were Stage IV mattress, reposition as needed, treatment as ordered, assess area of concern and notify MD/POA of status change. During observation on 8-22-12 at 1:45 p.m., CNA #6 and CNA #7 provided incontinence care for Resident #B. The resident had persistent loose stools during the care. The resident had a Stage IV open area on the lower end of the coccyx. The		compliance, the DNS/Designee is responsible for the completion of the wound/ skin CQI form weekly times 4 weeks, bi-monthly times 2 months and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. 5. Compliance Date 9/23/12	

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	area was was not covered with any type of dressing. The resident yelled during care "my bottom is killing me where I have been laying on this mattress." The physician telephone order for Resident #B, dated 8-22-12 at 3:30 p.m., indicated the resident may have a Stage 4 mattress to relieve pressure on coccyx. Clarification order indicated "Stage IV pressure area on coccyx- cleanse with normal saline, apply santyl/polysporin 1:3 mixture; calcium alginate and cover with transparent dressing daily. During observation on 8-23-12 at 10:05 a.m., the Wound Nurse measured Resident #B's pressure ulcer on her coccyx. The measurements were 3.4 cm by 2.5 cm by 0.2 cm in depth. The wound nurse indicated she did not know why the resident did not have a dressing on 8-22-12. The Wound Nurse indicated she got an order on 8-22-12 for clarification because the santyl/polysporin 1:3 mixture was not available yet. The Wound Nurse indicated she assumed that someone would put the dressing on after she obtained the order. The Wound Nurse indicated the nurse on the floor would have been responsible to do the treatment and dressing. Interview with the Wound Nurse on			

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	8-23-12 at 10:10 a.m., indicated Resident #B was admitted from the hospital on 8-20-12 with no orders for the Stage IV pressure ulcer. The Wound Nurse indicated the resident acquired the pressure ulcer at the hospital and did not have a pressure ulcer prior to hospitalization 8-13-12. The Wound Nurse indicated the resident had Mepilex covering the area when she returned from the hospital. The Wound Nurse indicated she faxed the physician on 8-20-12, but the physician would not have gotten the fax until the next day. The Wound Nurse indicated that on 8-21-12 she got an order for the santyl/polysporin, but the pharmacy had to mix it and it was not available at that time. The Wound Nurse indicated she called the physician back and got an order for calcium alginate until the santyl/polysporin was available. The Wound Nurse indicated the nurse on the floor should have put the treatment on the resident's Medication Administration Record (MAR). The Wound Nurse indicated she had to go work on the floor on another unit and told the floor nurse about the order. The Wound Nurse indicated she did not know if the floor nurse was aware the treatment had not been done yet. The Wound Nurse indicated the floor nurse would have been responsible to alert the CNA's that Resident #B had a pressure ulcer and that			

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	the resident had a dressing to the pressure ulcer. Review of the MAR for Resident #B indicated the pressure ulcer treatment for the Stage IV pressure ulcer was not signed as completed until 8-23-12 and was signed by the wound nurse. Interview with CNA #6 on 8-23-12 at 11:15 a.m., indicated no one had informed her that Resident #B had a pressure ulcer. When queried how did the aides know if a resident requires a dressing to a pressure ulcer to alert the nurse if there was none present, CNA #6 indicated some nurses will tell the aides and some do not tell if a resident has a pressure ulcer and dressing. CNA #6 indicated when she cared for Resident #B she did not know the resident was supposed to have a dressing in place. CNA #6 indicated all she knew was the resident was "hollering that her bottom was hurting her." The Skin Management Program policy provided by the Administrator on 8-22-12 at 8:45 a.m., included, but was not limited to, a head to toe assessment will be completed by a licensed nurse upon re-admission and documented on the nursing admission assessment. A physician order will be obtained for all			

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	alterations in skin integrity identified. Direct care givers will be notified of skin alterations and specific care needs and direct care givers will be notified of the resident's specific prevention interventions. This federal tag relates to Complaint IN00114311. 3.1-40(a)(2)			

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F0315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on observation, interview and record review, the facility failed to, provide proper peri (Perineal) care for 1 resident with a history of UTIs (Urinary Tract Infections) for 1 of 2 residents observed for peri care in a sample of 9. (Resident #A) Findings include: Resident #A's record was reviewed on 8/22/12 at 1:10 p.m. Resident #A's diagnoses included but were not limited to, urinary tract infection and diabetes mellitus. Resident #A's MDS (Minimum Data Set), assessment, dated 8/3/12, indicated the following: -BIMS (Brief Interview for Mental Status) was 10, with a range of 8-15, indicating moderately impaired cognition. - bed mobility, extensive assistance, one	F0315	It is the practice of this provider to ensure that each resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. 1. Resident A will receive appropriate treatment and services to prevent urinary tract infections. 2. Residents who are incontinent have the potential to be affected. A. Nursing staff will be in serviced on proper perineal care by the DNS/Designee by 9/23/12 3. A. C.N.A's will have peri care skills validation check completed by the DNS/Designee by 9/23/12 B. Charge nurse will conduct rounds on all shifts to ensure perineal care is performed according to appropriate	09/23/2012

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	person physical assist - toilet use, extensive assistance, one person physical assist - personal hygiene, extensive assistance, one person physical assist - bathing, physical help in part of bathing activity, one person physical assist - urinary continence, occasionally incontinent -bowel continence, always continent Resident #A's physician order indicated the following: - 7/10/12 at 10:00 a.m., "Start Ceftin (antibiotic),500 mg (milligram), by mouth, 2 times a day, times 10 days for UTI." Resident A's, care plan update, dated 7/10/12, indicated "Problem, UTI. Goal, will be resolved without problem. Interventions, give medication as ordered, monitor for adverse side effects, monitor vital signs every shift and notify MD as needed for any change." - 7/30/12 at 2:00 a.m., "Zyvox (antibiotic),600 mg. by mouth, 2 times a a day, times 10 days. Diagnoses: VRE (Vancomycin Resistant Enterococcus)/urine." Resident #A's, care plan update, dated 7/30/12, indicated "Problem, urinary infection. Goal, infection free. Interventions, antibiotic as ordered and		procedure C. Peri care skills validation check will be conducted during orientation and quarterly for all new C.N.A's. 4. To ensure compliance, the DNS/Designee is responsible for the completion of the perineal care technique skills validation form daily for 1 week, bi weekly for 1 week, bi-monthly times 2 months, and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. 5. Compliance Date 9/23/12	

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	encourage fluids." - 8/17/12 at 11:30 a.m., "Ceftin 250 mg, by mouth, twice a day, times 10 days for UTI." Resident A's, care plan update, dated 8/17/12, "Problem, UTI. Goal, will be resolved end antibiotics." During an observation on 8/22/12 at 3:00 p.m., CNA #3 was observed providing peri care to Resident #A. CNA #3 washed Resident #A's peri area from the back to the front. When CNA #3 rinsed Resident #A she went from the front to the back and Resident #A did not complain. During an interview with CNA #3 on 8/22/12 at 3:05 p.m., she indicated she was trained to wash from the front to the back, but Resident #A did not like her to do it that way. During an interview with Resident #A's family member on 8/22/12 at 9:00 a.m., the family member indicated Resident #A had never had a UTI prior to 4 months ago, after her admission. She stated "She is having UTIs and had to wear a diaper and she was soaked the day before yesterday and it is no wonder she has had UTIs."			

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	A document titled "Perineal Care" provided by the Administrator on 8/23/12 at 9:05 a.m., dated 2/2010, and indicated by the Administrator to be the most current policy, indicated ...Females: "separate labia and wash urethral area first, wash between and outside labia in downward strokes, alternate from side to side-wipe from front to back and from center of perineum outward and use a clean area of the wash cloth with each wipe. Do not rewipe area, unless using a clean area of the wash cloth. Change wash cloth as needed...." This Federal tag relates to complaint IN00114311. 3.1-41(a)(2)			

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F0323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to assist a resident with two staff to the bathroom resulting in the resident being lowered to the floor and acquiring a right femur fracture for 1 of 3 residents sampled for accidents in a total sample of 9 (Resident #B). Finding include: Review of the record of Resident #B on 8-22-12 at 1:35 p.m., indicated the resident's diagnoses included, but were not limited to, closed displaced right femur fracture, sacral decubitus ulcer, anemia, diabetes, dementia, anxiety and depression. The Minimum Data Set (MDS) assessment for Resident #B, dated 8-8-12, indicated the following: bed mobility-extensive assistance of one person, walk in room- did not occur and toilet use-extensive assistance of two people.	F0323	It is the practice of this provider to ensure the resident's environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. 1. Resident B will be transferred per C.N.A assignment sheet instruction and direction 2. A. Residents requiring transfers have the potential to be affected B. Nursing staff have been in serviced on proper transfer techniques by licensed therapist/designee by 9/23/12.3. A. PT/Designee will conduct skills validation for C.N.A's staff for proper transfer techniques B. Charge nurse/designee will conduct rounds on all shifts to ensure residents are properly transferred according to the C.N.A assignment sheet. The C.N.A assignment sheet will be changed during morning clinical meeting. The updated C.N.A assignment sheets will be provided to staff daily Monday-Friday. The charge nurse will review C.N.A assignment sheets with C.N.As at the start of each shift. 4. To ensure compliance, the	09/23/2012

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	The care plan for Resident #B, dated 5-17-12, indicated the resident was at risk for falls related to history of Cerebral Vascular Accident (CVA), incontinence, impaired gait/balance, use of a wheelchair and confusion. The interventions included, but were not limited to, assist resident with the use of assistive devices if indicated. The care plan did not indicate how much assistance was required. The care plan care plan for Resident #B, dated 5-17-12, indicated the resident required assistance with Activities Of Daily Living (ADL's) related to CVA, decreased mobility, confusion and disorientation. The interventions included, but were not limited to, assist resident in a.m. and p.m. care daily. The care plan did not indicate how much assistance was required. The care plan for Resident #B, dated 5-17-12, indicated the resident was at risk for skin breakdown related to decreased mobility, incontinence (chronic diarrhea), diabetes mellitus, heart disease, anemia and slides down in bed. The interventions included, but were not limited to, assist the resident with toileting and peri care after each incontinent episode. The care plan did not indicate how much assistance was required.		DNS/Designee is responsible for the completion of the transfer technique skills validation form daily for 1 week, bi weekly for 1 week, bi-monthly times 2 months, and then quarterly until continued compliance is maintained for 2 consecutive quarters. One skills validation will be completed on each unit per shift. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. 5.Compliance Date 9/23/12	

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	The fall circumstance report for Resident #B, dated 8-10-12 at 8:50 p.m., indicated the resident was being assisted with toileting needs by a CNA and a gait belt. When the resident was being assisted off the toilet the resident became weak and was lowered to the floor. The resident complained of right knee aching and indicated it always ached. The Medical Doctor was called and a new order was received to apply ice to the right knee as needed for pain. The nurses notes for Resident #B, dated 8-10-12, indicated the resident had been lowered to the floor in the bathroom by an CNA utilizing a gait belt. The resident became weak. The resident had a slight left knee abrasion, was able to move all extremities. The resident was assisted off the floor with a Hoyer lift. The resident voiced complaints of right knee pain and indicated it hurt prior to the assisted fall. The physician was notified. The nurses notes for Resident #B, dated 8-11-12 at 10:30 a.m., indicated a CNA attempted to assist the resident to change her clothes and sheets and the resident began screaming and grimacing with pain in her right hip. The right foot and ankle appeared to be slightly rotated outward. The right leg appears slightly longer than the left leg. The physician was notified.			

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The nurses notes for Resident #B, dated 8-11-12 at 10:50 p.m., indicated the resident right hip x-ray was negative for a fracture.

The nurses notes for Resident #B, dated 8-12-12 at 8:00 a.m., indicated the resident was screaming and grimacing in pain when her right leg was moved.

The nurses notes for Resident #B, dated 8-12-12 at 3:00 p.m., indicated the resident was unable to bear weight on her right leg and screams with pain. The physician was contacted to obtain an order for a complete right leg x-ray.

The x-ray for Resident #B, dated 8-12-12, indicated the resident had a right femoral fracture.

The nurses notes for Resident #B, dated 8-13-12 at 1:45 a.m., indicated the x-ray results were in and the physician was called and a new order was received to send the resident to the emergency room for oblique fracture of the right femur.

The Interdisciplinary progress note for Resident #B, dated 8-13-12 at 9:00 a.m., indicated on 8-10-12 the resident was being assisted to the restroom by one CNA and a gait belt to the toilet. The

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	resident complained of pain and became weak and the CNA assisted the resident to the floor. The resident acquired a fracture and was sent to the hospital for treatment and evaluation. The discharge summary from the local hospital for Resident #B, dated 8-20-12, indicated the resident presented to the emergency room on 8-13-12 after having a fall at her nursing home 2-3 days previously. The initial x-ray report was negative, the resident had persistent pain and a repeat x-ray showed a comminuted oblique fracture through the lower diaphysis of the right femur. The resident had rod placement in the right femur on 8-16-12 "which was accomplished with significant complications." The discharge instructions included, but were not limited to, wear knee immobilize on her right knee when in bed and when up with physical therapy, weight bearing as tolerated to right lower extremity with walker and gentle range of motion with right knee daily. Interview with CNA #10 on 8-22-12 at 5:40 p.m., indicated she was assisting Resident #B to the toilet on 8-10-12 when the resident was lowered to the floor in the bathroom. CNA #10 indicated she assisted the resident to the toilet using a gait belt. CNA #10 indicated after the			

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	resident was done using the restroom, she assisted the resident to a standing position and began cleaning the resident. CNA #10 indicated the resident began saying she had to sit down and that her leg was hurting her. CNA #10 indicated she assisted the resident back on to the toilet with a gait belt, but the resident was only partially on the toilet seat. CNA#10 indicated the resident had both legs straight out in front of her and she attempted to have the resident put her legs on the floor and the resident kept saying "no no honey I'm hurting." CNA #10 indicated she then lowered the resident from the toilet to the floor. CNA #10 indicated she called for help from staff and they used a Hoyer lift to get the resident off the floor. CNA #10 indicated Resident #B normally required 1 to 2 people to assistance with toileting needs and transfers depending on how the resident was feeling. This Federal tag relates to Compliant number IN00114658. 3.1-45(a)(2)			

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F0329 SS=J	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.			
	Based on observation, interview and record review, the facility failed to obtain a laboratory test ordered by the physician to monitor the effects of Coumadin (blood thinner) therapy after an increase in the Coumadin dose, failed to assess for bruises and complete any follow-up assessment of the 20 bruises after they were found or assessed for any new bruising for 1 of 6 residents reviewed for Coumadin therapy in a sample of 9. (Resident #A)	F0329	It is the practice of this provider to ensure that each resident's drug regimen is free from unnecessary drugs. An unnecessary drug is any drug used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinue these drugs. 1. Resident A is monitored for PT/INR per physician order 2. A. Residents receiving Coumadin	09/23/2012

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	The IJ (Immediate Jeopardy) began on 7/24/12, when the facility failed to monitor the effects of Coumadin and failed to obtain the physician ordered PT/INR lab to monitor the effects of the Coumadin. The DON (Director of Nursing), Administrator and Corporate Nurse were notified of the immediate jeopardy at 4:17 p.m. on 8/23/12. The immediate jeopardy was: removed on 8/24/12, but noncompliance remained at the lower scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: Resident #A's record was reviewed on 8/22/12 at 1:10 p.m. Resident #A's diagnoses included but were not limited to chronic ischemic heart disease, anemia, cardiomegaly (enlarged heart) depression and atrial fibrillation (irregular heart beat). Resident #A's MDS (Minimum Data Set), assessment, dated 8/3/12, indicated the following: - BIMS (Brief Interview for Mental Status) was 10, with a range of 8-15, indicating moderately impaired cognition - bed mobility, extensive assistance, one		have the potential to be affected. B. Licensed nurses were in serviced by corporate director of education/ designee on lab results monitoring and MD notification of abnormal labs, use of the lab tracking log form and change of condition policy. C. Nursing staff will be in serviced on any abnormal skin conditions (bruising, open areas, rashes, skin tears or blisters) by DNS/ designee. CNAs will also be in serviced on the reporting unusual conditions to the charge nurse and completion of shower reports. D. The charts were reviewed by DNS/ designee for all residents who had prescribed Coumadin to ensure appropriate physician orders and lab monitoring was in place. 3. A. Licensed nurses were in serviced by DNS/ designee on lab results monitoring and MD notification of abnormal labs, use of the lab tracking log form and change of condition policy. B. Nursing staff will be in serviced by DNS/ designee on any abnormal skin conditions (bruising, open areas, rashes, skin tears or blisters). CNAs will also be in serviced on reporting abnormal skin conditions to the charge nurse and completion of shower reports. C. Coumadin tracking log is in place to monitor dosage/lab value/ MD notification and any new orders received after every INR draw.The charge nurses are responsible for updating	

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	person physical assist - transfer, extensive assistance, one person physical assist - walk in room, extensive assistance, one person physical assist - walk in corridor, activity did not occur - toilet use, extensive assistance, one person physical assist - personal hygiene, extensive assistance, one person physical assist - bathing, physical help in part of bathing activity, one person physical assist - mobility devices, wheelchair - urinary continence, occasionally incontinent - bowel continence, always continent Resident #A had a "Coumadin/Warfarin PT (Prothrombin Time)/INR) (International Normalization Ratio) (bleeding times) Tracking Log" record. The log had sections for current dose, PT/INR results, MD notification, and dosage change/comments. The record had been completed on 6/18/12 and included: Coumadin 3 mg (milligram), daily. PT, 22.1 and INR, 2.14. Comments 3 mg Coumadin daily. The entry on 6/18/12 was the last entry on the "Coumadin/Warfarin INR Tracking Log" Resident #A's PT/INR lab on 7/16/12 indicated PT, 12.7 and INR, 1.22.		the Coumadin tracking log. The charge nurse is responsible for notifing the MD of lab results. The log will be audited daily by the DNS/Designee. D. DNS or designee will audit resident care plans to ensure care plans are current and specific to resident's treatment. E. Resident's skin will be assessed two times each week for bruising/rashes and documented on the skin assessment form by the Charge Nurse. 4. To ensure compliance, the DNS/Designee is responsible for the completion of the Coumadin CQI form weekly times 4 weeks, bi-monthly times 2 months and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. 5.Compliance Date 9/23/12	

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	Resident #A's physician orders, dated 7/17/12, indicated "discontinue Coumadin 3 mg, "Start, Coumadin 4 mg, by mouth, daily and check PT/INR levels, (normal, PT , 9.5-11.8/INR, 0.9-1.1) in 1 week on 7/24/12." Resident #A's, "care plan update" written by the facility under the physician's orders, dated 7/17/12, indicated "Problem, prophylactic. Goal, will continue without problem. Interventions, give medication as ordered, obtain labs as ordered, notify, physician as needed, monitor for adverse side effects, monitor for abnormal bruises and notify Power of Attorney." Resident #A's MAR (Medication Administration Record), indicated from July 17, 2012 through August, 12, 2012 Resident #A had received 4 mg of Coumadin daily. Resident #A's physician orders, dated 8/12/12 at 8:30 p.m., indicated "STAT lab PT/INR and CBC (Complete Blood Count)" Resident #A's "care plan update" written by the facility under the physician's orders, dated 8/12/12, indicated "Problem, bruise (multiple). Goal, skin normal no bruising. Interventions, STAT lab PT/INR and CBC, skin checked by nurse 1 time/week and observe for increased bruising."			

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Resident #A's PT/INR was obtained on 8/12/12, indicated PT, 130.2 and INR 13.73.

Resident #A's physician orders, dated 8/13/12, indicated "Hold Coumadin (indefinite time), give Vitamin K (to reduce PT/INR) 10 mg IM (intramuscular) now and recheck PT/INR on Wednesday 8/15/12"
Resident #A's "care plan update" written by the facility under the physician's orders, dated 8/13/12, indicated "Problem, increased PT/INR. Goal, maintain PT/INR, within normal limits. Interventions, Hold Coumadin (indefinite time), give vitamin K 10 mg IM now, recheck PT/INR on Wednesday 8/15/12, and monitor for signs symptoms of bleeding."

Resident #A's PT/INR on 8/15/12, indicated PT, 12 and INR 1.16.

Resident #A's care plan, dated 11/21/11, indicated "Problem, resident is at risk for abnormal/excessive bleeding due to use of anticoagulant medication Coumadin. Goal, (long term goal target date: 02/23/2012, resident will be free from signs of hemorrhage/abnormal bleeding. Interventions, call light within reach at all times, labs as ordered, medication as

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	ordered, notify MD and family of any status changes and as needed, observe for adverse effects of medication such as blurred vision, nausea, decreased appetite, headache, joint pain and shortness of breath, observe for signs of bleeding: blood tinged sputum, excessive bruising, bruise increasing in size, oozing from superficial injuries, bleeding gums." Resident #A's nursing notes, dated 8/12/12 at 12:05 p.m., included, "vitamin K 10 mg, IM given in left deltoid.... Resident educated to call for assist, use extra caution to prevent bumping or scratching self." Lippincott Williams and Wilkins, Nursing 2012 Drug Handbook, indicated for Coumadin a "Black Box Warning" of "Can cause major or fatal bleeding, which is more likely to occur during the starting period and with a higher dose. Regularly monitor INR in all patients. Consider more frequent INR monitoring in those at high risk for bleeding." Resident #A's nursing's notes indicated the following: (Resident #A's 7/16/12 INR lab results were INR, 1.22) - 7/17/12 at 10:05 a.m., indicated "new order discontinue Coumadin 3 mg, by,			

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	mouth, daily. Start Coumadin 4 mg, by mouth, check PT/INR in 1 week on 7/24/12." - 8/12/12 at 8:00 p.m., indicated "CNA reported to this nurse that resident had family in room and they wanted to know where bruises came from. So read through a week of nurse's notes and nothing found related to bruises or cause. Talked with shift supervisor and we talked with family and family very upset. Called physician and received order for STAT lab draw. Family notified. Resident does have multiple bruises on bilateral arms, back, abdomen and right foot. Some are dark purple, some are various, shades of blue and green. Shift supervisor and this writer did head to toe assessment. Will continue to monitor. - 8/12/12 at 9:50 p.m., complete blood count, PT/INR, drawn...sent to lab for STAT run - 8/12/12 at 9:52 p.m., all bruises were measured with assistance of shift supervisor with the assistance of staff and recorded on the wound skin evaluation report. - 8/12/12 at 11:30 p.m., lab results from lab, PT, 130.2, INR, 13.7 and hemoglobin (red blood cells that carry oxygen) 10.5 (normal values, 12.0-16.5), hematocrit 32.4 (normal values, 36-43.) - 8/12/12 at 11:35 p.m., call placed to lab to contact, physician informed of PT/INR			

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	results. New order received: 1. Hold Coumadin (indefinite time). 2. Give vitamin K, 10 mg IM now. 3. Recheck PT/INR Wednesday. - 8/12/12 at 12:05 p.m.," vitamin K, 10 mg, IM given in left deltoid.... Resident educated to call for assist, use extra caution to prevent bumping or scratching self." Resident #A's "Wound Skin Evaluation Report," dated 8/12/12, indicated the following bruises: - right elbow, 9 cm X 5 cm - right anterior upper arm, 6 cm X 3 cm - right posterior upper arm, 5 cm X 3 cm - right forearm, 5 cm X 3 cm - left wrist, 3 cm X 1 cm - left forearm, 0.5 cm X 0.5 cm - left forearm, 3.5 cm X 2.5 cm - left upper arm, 6.5 cm X 4.5 cm - left posterior upper arm, 8 cm X 2.5 cm - left posterior upper arm, 3 cm X 2 cm - left posterior upper arm, 1 cm X 0.5 cm - left upper medial arm, 6 cm X 3 cm - right foot/toe, 7.3 cm X 3 cm - left knee, 1.5 cm X 1 cm - left medial back, 3 cm X 1 cm - left medial back, 1 cm X 0.5 cm - left medial back, 3 cm X 1.5 cm - left medial back, 2 cm X 1 cm - left lower back, 2.5 cm X 1 cm - left lower back, 2 cm X 1 cm			

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	During an observation on 8/22/12 at 1:15 p.m., Resident #A was observed in bed with the head of the bed in the up position, her right upper arm, just above her elbow had a large approximately 8 cm (centimeters) X 5 cm, dark purple bruise. Her lower right arm had 3 bruises with some fading of dark purple bruising at varies sizes. The largest area was approximately 6 cm X 3 cm, the next to the largest was, approximately 4 cm X 2 cm and the smallest bruise on her wrist was approximately 3 cm X 1 cm. During an interview on 8/22/12 at 1:30 p.m., Resident #A indicated she had so many bruises because of the blood thinner she was taking. An interview with Resident #A's family member on 8/22/12 at 9:00 a.m., indicated the bruising on Resident #A was found on 8/12/12 by two family members and when the facility was informed of the bruising and looked at all the bruises all over her entire body the facility's response was the resident was on blood thinners. The family member indicated the resident was covered with bruising and there had not been a problem like that in the past. The family member stated "On 8/12/12 when the family informed the facility of the bruising the facility acted like the bruising was normal because the resident			

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	was on blood thinners." The family indicated the resident did not know how she acquired the bruising but her foot was hurting her so bad and her foot was swollen, and black. The family member also indicated prior to the bruising on 8/12/12, the resident required 2 staff members for her transfers, 1-2 staff for bed mobility and toilet use, bathing took a total of 2 staff and dressing was with the assistance of one staff. During an interview on 8/22/12 at 2:00 p.m., LPN #1 indicated Resident #A had multiple bruises and a hematoma on her foot that came from her PT/INR being too high. During an interview on 8/22/12 at 5:30 p.m., the Director of Nursing (DON) indicated the physician had ordered an x-ray for Resident #A's foot, but the physician felt the edema and bruising on her right foot was from the blood pooling in her foot because of the effects of the high PT/INR and the x-ray of the resident's foot was negative. During an interview on 8/22/12 at 6:00 p.m., the DON indicated a PT/INR for 7/24/12 had not been done. She stated "I called the lab and they did not have any record of it being ordered." The DON also indicated there was no weekly skin			

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	assessments completed on Resident #A. During an interview on 8/23/12 at 10:15 a.m., with the Laboratory Supervisor, from the laboratory where the facility's labs are ordered to be done, the Supervisor indicated the laboratory had not received an order by fax or telephone for a PT/INR for 7/24/12. During an interview with the Wound Nurse on 8/23/12 at 11:05 a.m., she indicated she had not done any other assessment or measurement of the bruises since 8/12/12. During an interview on 8/23/12 at 11:25 a.m., the DON indicated when they receive an order for a lab test, the nurse fills out a lab request and faxes it to the lab, puts it in the lab book and the laboratory will fax back a draw sheet of who they are going to draw and then the nurse compares the fax and the the facility treatment book and the lab book. The floor nurse is responsible to ensure labs are drawn. During an interview on 8/23/12 at 3:20 p.m., the DON indicated the nurses on the floor were responsible for monitoring bruising and they know they are responsible to measure and monitor bruising. She stated "I do not know why			

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	they did not monitor for bruises before 8/12/12 or do follow-up assessments on the bruising," During an observation with the Wound Nurse on 8/23/12 at 4:15 p.m., Resident #A's bruises were assessed with the following measurements: - right elbow, 7.4 cm X 11.5 cm - right anterior upper arm, 12 cm X 4 cm - right posterior upper arm, 3 cm X 4.4 cm - right forearm, 4.4 cm X 3.4 cm - left wrist, 2 cm X 1 cm - left forearm, 1 cm X 0.7 cm - left upper arm, 5.0 cm X 4 cm - left posterior upper arm, 5.5 cm X 2.8 cm - right shin, 1 cm X 1 cm - left posterior upper arm, 3 cm X 2 cm - left posterior upper arm, 1 cm X 0.5 cm - left upper medial arm, 6 cm X 3 cm - right foot/toe, 5.5 cm X 1.4 cm - left knee, 1.5 cm X 1 cm - left medial back, 4.7 cm X 2 cm - left medial back, 2 cm X 1 cm - left lower back, 2.5 cm X 1 cm - left lower back, 2 cm X 1 cm During an interview with the Wound Nurse on 8/23/12 at 5:00 p.m., she indicated the bruises were fading and were not nearly as dark purple as they were on 8/12/12.			

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	A document titled "Warfarin/Coumadin" provided by the Administrator on 8/23/12 at 8:30 a.m., dated 7/20/11, and indicated by the Administrator to be the most current policy, included: "Purpose: To ensure that residents taking Warfarin/Coumadin do not experience a drug to drug, or drug to food adverse reaction. Procedure: Before receiving Warfarin/Coumadin the resident must have a PT/INR lab test, once the resident's PT/ INR are stable, a PT/INR will be drawn as per the physician's order and the nurse will document her/his review of the resident's medication, the physician's notification and the physician's response in the nurse's notes." The immediate jeopardy that began on 7/24/12 was removed on 8/24/12 when the facility inserviced the CNAs and nurses on adverse effects of Coumadin including bleeding and bruising, residents on Coumadin were indicated on the CNAs assignment sheet, the nursing staff were instructed to document skin assessments twice a week on all residents on Coumadin, and the PT/INR monitoring tool is to be documented on the Treatment Administration Record when applicable. Any new orders received in the evening, nights or on the weekend were to be			

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	155377	A. BUILDING 00 B. WING	08/24/2012

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	documented on the 24 hour report then go on the lab sheet. The nurses were inserviced on the lab tracking log and to monitor the physician orders for labs and lab results and to make sure to write the physician order in the lab book. The facility will utilize lab services and monitor results on the CQI (Certified Quality Inspector) tool daily also on weekends and monitor daily on the lab tracking log on the clinical record Monday thru Friday. Nurses and CNAs were interviewed on their knowledge of the adverse effects of Coumadin and CNAs also demonstrated understanding of the effects and risks of Coumadin, also how to monitor the effects and when to report significant changes. The interdisciplinary team will review physician orders and the laboratory tracking log in the clinical meeting Monday thru Friday but noncompliance remained at the lower scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy because of the need for on going auditing and inservicing. This federal tag relates to complaint IN00114311. 3.1-48(a)(3)			

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